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CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES (CHAMPUS)

The Assistant Secretary of Defense (Health Affairs), has authorized the following page changes to DoD 601 0.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

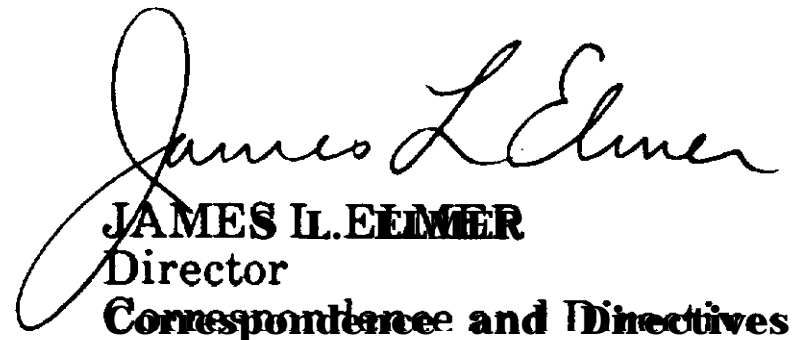
Remove: 2-iii&2-iv, 2-23&2-24, 4-i through 4-iv, 4-vii&4-viii, 4-5&4-6, 4-9 through 4-14,4-17 through 4-20,4-50 through 4-55, 6-i&6-ii, 6-3&6-4, 6-12 through 6-13b,14-i&14-ii, 14-3 through 14-10a, and 14-21 through 14-23

Insert: Attached replacement pages and new pages 4-6a&4-6b,4-9a&4-9b, 4-12a& 4-12b, 4-13a& 4-13b, 14-3 through 14-10a, and 14-24 through 14-26

Changes appear on pages 2-iv, 2-23, 4-i through 4-iii, 4-vii, 4-viii, 4-5&4-6, 4-9 through 4-12,4-18,4-19,4-50, 4-52,4-53,4-55, 6-i, 6-3,6-12 through 6-13a and are indicated by marginal bars. Pages 14-3 through 14-10a to Change No. 24, March 1987, were inadvertently omitted from the July 1991 (Reprint). Changes also appear on pages 14-i&14-ii, 14-21 through 14-23 and are indicated by marginal asterisks.

EFFECTIVE DATE

The above changes are effective immediately.


JAMES L. ELMER
Director
Correspondence and Directives

Attachments
61 pages

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

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Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which **meets the** criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, **levin** tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, **retirée**, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

CHAPTER 4

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c. Documentation for preauthorization - approved treatment plan.
A request for preauthorization described in subsection All. of this chapter, requires submission of a detailed treatment plan, in accordance with guidelines and procedures issued by the Director, **OCHAMPUS**.

d. Other preauthorization requirements

(1) The Director, **OCHAMPUS**, or a designee, shall respond to all requests for preauthorization in writing and shall send notification of approval or **denial** to the beneficiary.

(2) The Director, **OCHAMPUS**, or a designee, shall specify, in the approved preauthorization, the services and supplies the approval covers.

(3) An approved preauthorization is **valid** only for 90 days from the date of issuance. If the **preauthorized** services and supplies are not obtained or commenced within the 90-day period, a new preauthorization request is required.

(4) A preauthorization may set forth other special **limits** or requirements as indicated by the particular case or situation for which preauthorization is being issued.

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, **OCHAMPUS** shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory preadmission authorization before **nonemergency** inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and outpatient care, retrospective review, and other such procedures as determined appropriate by the Director, **OCHAMPUS**. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, **OCHAMPUS**, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that **would be provided** if the preadmission requirements had been met.

(2) In cases of noncompliance with preadmission authorization requirements, institutional payment will be reduced by the amount attributable to the days of services without the appropriate certification up to a maximum of five days of services. In cases in which payment is determined on a prospectively set per-discharge basis (such as the DRG-based payment system), the reduction shall be \$500 for each day of services provided without the appropriate preauthorization, up to a maximum of five days of services.

(3) For purposes of paragraph **A.12.b.** (2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph **A.12.b.** (2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, **OCHAMPUS**, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to implement the intent of this Regulation.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional" **care** for which **Basic** Program benefits may be extended must be at the appropriate **level** required to provide the medically necessary treatment. If an appropriate lower level care facility **is** adequate, but is not available **in** the general locality, benefits may be continued in the higher level care facility, but CHAMPUS institutional benefit payments shall be limited **to** the allowable cost that would have been incurred in the appropriate lower level care facility, as determined by the Director, **OCHAMPUS**, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related **to** the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or **not** payable by the cognizant public entity. Each case must be referred to the Director, **OCHAMPUS**, or a designee, for review and a determination of the applicability of CHAMPUS benefits,

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

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k. Chemotherapy.

l. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, **OCHAMPUS**, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

4. Services and supplies provided by RTCS

a. Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised **reasonable** recreational and social activity services, and other general services as considered appropriate by the Director, **OCHAMPUS**, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her **fundamental** needs, that is, physical, psychological, chronological age, developmental **level**, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of **mental** disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph **C.3.i.** of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, **OCHAMPUS**. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

g. Criteria for determining medical or psychological necessity-. In determining **the medical** or psychological necessity of services and supplies provided by RTCS, the evaluation conducted by the Director, **OCHAMPUS** (or designee) shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. In addition to the criteria set forth in this paragraph B.4. of this chapter, additional evaluation standards, consistent with such criteria, may be

adopted by the Director, **OCHAMPUS** (or designee). RTC services and supplies shall not be considered medically or psychologically necessary unless, at a minimum, all the following criteria are clinically determined in the evaluation to **be fully** met:

(1) Patient has a diagnosable psychiatric disorder.

(2) Patient exhibits patterns of disruptive behavior with evidence of disturbances in family functioning or social relationships and persistent psychological and/or emotional disturbances.

(3) RTC services involve active clinical treatment under an individualized treatment plan that provides for:

(a) Specific level of care, and measurable goals/objectives relevant to each of the problems identified;

(b) Skilled interventions by qualified mental health professionals to assist the patient **and/or** family;

(c) Time frames for achieving proposed outcomes; and

(d) Evaluation of treatment progress to include timely reviews and updates as appropriate of the patient's treatment plan that reflects alterations in the treatment regimen, the measurable goals/objectives, and the level of care required for each of the patient's problems, and explanations of any failure to achieve the treatment goals/objectives.

(4) Unless therapeutically contraindicated, the **family and/or** guardian must actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy. (In the latter case, the treatment center must document that there has been collaboration with the family **and/or** guardian in **all** reviews.)

h. Preauthorization requirement.

(1) **All** admissions to RTC care are elective and must be certified as medically/psychologically necessary prior to admission. The criteria for **preauthorization** shall **be** those set forth in paragraph **B.4.g.** of this chapter. In applying those criteria in the context of preadmission authorization review, special emphasis is placed on the development of a specific diagnosis/treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The plan must be under development at the time of the admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission. -

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) Preauthorization requests should be made not less than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Preauthorizations are valid for 90 days.

i. Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing

provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation;
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(c) When a patient (in need of immediate inpatient care but not requiring a private room) is **admitted** to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost **of** private accommodations is covered under the circumstances described in subparagraph **B.5.a. (2)** of this chapter until the patient's condition no longer requires the private room for **medical** reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an **otherwise** covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. "When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no **semi-private accommodations, for any inpatient day when the patient qualifies for** use of a **private** room (as set forth in subparagraphs **B.5.a. (2)(a)** and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, **OCHAMPUS**, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not **limited** to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other

authorized institution is **called** in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty **(special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply).**

c. ICU. An ICU is a special segregated unit of a hospital in which **patients are concentrated, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room.** In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUS if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a **hospital** or other authorized institution only under the following conditions:

(1) They represent a cost to the facility rendering treatment;

(2) They are furnished to a patient receiving treatment, and are related directly to that treatment; and

(3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

(1) If ordinarily furnished by the facility for the care and treatment of patients; and

(2) If specifically related to, and in connection with, the condition for which the patient is being treated; and

(3) If ordinarily furnished to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and

(4) Use of durable medical equipment is limited to those items provided while the patient is **an** inpatient. If such equipment is provided for **use** on an outpatient basis, the provisions of section D. **of** this chapter apply.

g. Transitional use items. Under certain circumstances, a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue **the patient's** use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are considered a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

6. Inpatient mental health services. Inpatient mental health services are those services furnished by institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless otherwise exempted, a specialized treatment facility.

a. Criteria for determining medical or psychological necessity. In determining the medical or psychological necessity of acute **inpatient** mental health services, the evaluation conducted by the Director, **OCHAMPUS** (or designee) shall consider the appropriate **level** of care for the patient, the intensity of services required by the patient, and the availability of that care. The purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive **model** of inpatient care in order to permit management of the patient's condition at a less intensive **level** of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. In addition to the criteria set forth in this paragraph **B.6.** of this chapter, additional evaluation standards, consistent with such criteria, may be adopted by the Director, OCHAMPUS (or designee) - Acute inpatient care shall not be considered necessary unless the patient needs to be observed and assessed on a 24-hour basis by skilled nursing staff, **and/or** requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

(1) Patient poses a serious risk of harm to self **and/or** others.

(2) Patient is in need of high dosage, intensive medication or **somatic** and/or psychological treatment, with potentially serious side effects.

(3) Patient has acute disturbances of mood, behavior, or thinking.

b. **Emergency admissions.** Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those **in** paragraph **B.6.a.** of this chapter, - must be met:

(1) the patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (**or** other qualified mental health professional with hospital admission authority); and

(2) the patient requires immediate continuous skilled observation and treatment at the acute psychiatric **level** of care.

c. **Preauthorization requirements.**

(1) **All** non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in paragraph **B.6.a.** of this chapter. In applying those criteria in the context of preauthorization review, special emphasis is placed **on** the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

(2) The timetable for development of the individualized treatment plan shall be as follows:

(a) The development of the plan must begin immediately upon admission.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within five calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive **biopsychosocial** assessment and diagnostic formulation;

(d) **A** specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) The request for preauthorization must be received by the reviewer designated by the Director, **OCHAMPUS** prior to the planned **admission**. **In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. However, if the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall be the date of approval.**

(5) Authorization prior to admission is not required in the case of a psychiatric emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the Director, **OCHAMPUS** or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

d. Concurrent review. Concurrent review of the necessity for continued stay will be conducted. The criteria for concurrent review shall be those set forth in paragraph **B.6.a.** of this chapter. In applying those criteria in the context of concurrent review, special emphasis is **placed** on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

7. Emergency inpatient hospital services. In the case **of** a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. **If** the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits **no** longer are payable in that hospital.

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a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

8. RTC day limit.

a. With respect to mental health services provided on or after October 1, 1991, benefits for residential treatment are generally limited to 150 days in a fiscal year or **150 days** in an admission (not including days of care prior to October 1, 1991). The RTC benefit limit is separate from the benefit limit for acute inpatient mental health care.

b. Waiver of the RTC day limit.

(1) There is a statutory presumption against the appropriateness of residential treatment services in excess of the 150 day limit. However, the Director, **OCHAMPUS**, (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable **criteria** have been met, waive the RTC benefit limit in paragraph **B.8.a.** of this chapter and authorize payment for care beyond that limit.

(2) The criteria for waiver shall be those set forth in paragraph **B.4.g.** of this chapter. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

(a) Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

(b) The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

(c) Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

(d) The waiver request includes specific time frames and a specific plan of treatment which will lead to discharge.

(3) Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and **adjunctive** resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit **limit**.

(4) It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

c. RTC day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

9. Acute care day limits.

a. With respect to mental health care services provided on or after October 1, 1991, payment for inpatient acute hospital care is, in general, statutorily limited as follows:

(1) Adults, aged 19 and over - 30 days in a fiscal year or 30 days in an admission (excluding days provided prior to October 1, 1991).

(2) Children and adolescents, aged 18 and under - 45 days in a fiscal year or 45 days in an admission (excluding days provided prior to October 1, 1991) .

b. It is the patient's age at the time of admission that determines the number of days available.

c. Waiver of the acute care day limits.

(1) There is a statutory presumption against the appropriateness of inpatient acute services in excess of the day limits set forth in paragraph **B.9.a.** of this chapter. However, the Director, **OCHAMPUS** (or designee) may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the acute inpatient limits described in paragraph **B.9.a.** of this chapter and authorize payment for care beyond those limits.

(2) The criteria for waiver of the acute inpatient limit shall be those set forth in paragraph **B.6.a.** of this chapter. In applying those criteria in the context of waiver request review, special emphasis is placed on determining whether additional days of acute inpatient mental health care are medically/psychologically necessary to complete necessary elements of the **treatment** plan prior to implementing appropriate discharge planning. A waiver may also be granted in cases in which a patient exhibits well-documented new symptoms, **maladaptive** behavior, or medical complications which have appeared in the inpatient setting requiring a significant revision to the treatment plan.

(3) The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay beyond the date of the inpatient limit. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provision.

(4) For patients in care at the time the inpatient limit is reached, a waiver must be requested prior to the **limit**. For patients being readmitted after having received 30 or 4s **days in** the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

d. Acute care day limits do not apply to services provided under the Program for the Handicapped (Chapter 5 of this Regulation) or services provided as partial hospitalization care.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth

in **this or other chapters of this Regulation. Except as otherwise** specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there **should** be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a **fee-for-service** basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit **CHAMPUS** to determine whether benefits are authorized by this Regulation. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

Bronchoscopy

Laryngoscopy

Thoracoscopy

Catheterization of the heart

Arteriograph thoracic lumbar

Esophagoscopy

Gastrosocopy

Proctoscopy

Sigmoidoscopy

Peritoneoscopy

Cystoscopy

Colonoscopy

Upper G.I. panendoscopy

Encephalograph

Myelography

Discography

Visualization of intracranial aneurysm by **intracarotid** injection of dye, with exposure of carotid artery, unilateral

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c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the **nonavailability** of a qualified intern, resident, or other house physician. When a claim is received for a surgical **assistant** involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal **aftercare**, whether the **aftercare** is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including **the** removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it- is impracticable for the beneficiary **to** use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one **individual professional** provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple condition's that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed **within** 3 days of surgery by the attending **physician** is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not-payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general-or psychiatric hospitals, **RTCs**, or specialized treatment facilities, as authorized by the Director, **OCHAMPUS**, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, **OCHAMPUS**, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, **OCHAMPUS**, or a designee. In order to qualify for **CHAMPUS** mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the most current edition' of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder, " or V codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or **social** roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental **health** providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and marriage and family, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph **C.3.i.** (1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychological Association or the American Psychiatric Association and when preauthorized by the Director, **OCHAMPUS**, or a designee.

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(e) Psychological testing and assessment. **Psychological** testing and assessment is generally limited to six hours of testing in a fiscal year when medically or psychologically necessary and in conjunction with otherwise covered psychotherapy. Testing or assessment in excess of these limits requires review for medical necessity. Benefits will not be provided for the **Reitan-Indiana** battery when administered to a patient under age five, for self-administered tests administered to patients under age 13, or for psychological testing and assessment as part of an assessment for academic placement.

(f) Administration of psychotropic drugs. When prescribed by an authorized **provider qualified by licensure** to prescribe drugs.

(g) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, **OCHAMPUS**.

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph **C.3.i.(2)** of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, **conjoint**, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when authorization has **been granted for** the **maximum** number of inpatient-mental health days in accordance with the limits as described in this Chapter 4, unless additional coverage is granted by the Director, **OCHAMPUS** or a designee.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient, residential treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

(4) Review of claim^s for treatment of mental disorder. The Director, **OCHAMPUS**, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) **shall** refer the patient for treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length **or** frequency requires documentation of the medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

(2) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a physician, a physician shall prescribe the treatment and **a** physician shall supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a **CHAMPUS-authorized** institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part of an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not considered CHAMPUS-authorized providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable **for well-baby** care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, or a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella) .
- (f) Tuberculin test, **hematocrit** or Hgb., and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance **of** the individual case are covered if medically necessary **'and** otherwise authorized for benefits under CHAMPUS .

- d. Rh immune globulin.
- e. Genetic tests as specified **in** paragraph **E.3.b.** of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of **active** duty military personnel who **are** traveling outside the United States **as a** result of **an** active **member's duty** assignment and such travel is being performed under orders issued by **a** Uniformed Service.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether **or not** such services would be eligible for benefits if rendered by **an** authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of **a** diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for **socio-economic** purposes, diabetic self-education programs, **stress** management, life style modification, etc. Services provided by **a** marriage and family, pastoral **or** **mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMFUS-determined allowable cost-rate.**

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE : In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, **in** accordance with the CHAMPUS-determined allowable charge, for **one wig or** hairpiece per beneficiary (lifetime **maximum**) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has **not** been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or **any** other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

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42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.I.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even **if** recommended by a physician and regardless of whether or "not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program **of** physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, **except** when prescribed by a physician and rendered as a part **of** treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations **except as** specifically provided in paragraph **C.2.p.** of this chapter or except when rendered in connection with medical **or** surgical treatment **of** a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with **otherwise** covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, **except as specifically** provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for **transtelephonic** monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

58. Enuresis. Enuretic devices; enuretic conditioning programs.

59. RESERVED.

60. Autopsy and postmortem.

61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.

62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion,

63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.

64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.

65. "stop smoking" programs. Services and supplies related to "stop smoking" regimens.

66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.

67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.

68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.

69. Institutions. Services and supplies provided by other than a hospital, unless the institution has been approved specifically by **OCHAMPUS**. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

NOTE : In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic **services** including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service) .

71. Supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. Effective for care received on or after October 1, 1991, services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient nineteen years of age or older, 45 days in

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any fiscal year **(or in an admission) in the case of** a patient under 19 **years of age, or 150 days in any fiscal year (or in an admission)** in the case of inpatient mental health services provided **as** residential treatment **care**, unless coverage for such services is granted by a **waiver** by the Director, **OCHAMPUS**, or a designee. In cases involving **the day** limitations, waivers **shall be** handled in accordance with paragraphs B.8. **or** B.9. of this chapter. For services prior **to** October 1, 1991, services in excess **of 60 days in any** calendar year unless additional coverage is granted by the Director, **OCHAMPUS, or** a-designee.

73. Economic interest in connection with mental health admissions. Inpatient mental health services (including both acute care and RTC services) **are** excluded for care received when **a patient is** referred **to a** provider of such services by a physician (or other health **care** professional with authority to **admit**) **who has an** economic interest in the facility to which the patient is referred, unless **a waiver is** granted. Requests for waiver shall be considered under the same procedure and based on the same criteria as used for obtaining preadmission authorization (**or** continued stay authorization for emergency admissions), with the only additional requirement being that the economic interest be disclosed as part of the request. The same reconsideration and appeals procedures that apply to day **limit** waivers shall also **apply** to decisions regarding requested waivers of the economic interest exclusion. However, a provider may appeal a reconsidered determination that an economic relationship constitutes an economic interest within the scope of the exclusion to the same extent that a provider may appeal determinations under paragraph 1.3., Chapter 15. This exclusion does not apply **to services** under the Program for the Handicapped (Chapter 5 of this Regulation) or provided **as** partial hospital care. If a situation arises where **a** decision is made **to** exclude CHAMPUS payment solely on the basis of the provider's economic interest, the normal CHAMPUS appeals process will be available.

74. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined **to be** covered within the intent of this Regulation by the Director, **OCHAMPUS**, or a designee, even though not otherwise listed.

NOTE : The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that **apply only** to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary") . (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not **apply** to coverage determinations made by **OCHAMPUS** or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain-potentially excludable expenses. Services determined under the PRO program **to be** potentially excludable by reason of the exclusions in

section G. of this chapter for not medically necessary services **will** not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services. as if the exclusions did not apply.

3. Liability for certain excludable **services**. In any case in which items or services **are** determined excludable by the PRO program by reason of being not medically necessary and payment may not be made under subsection **H.2.**, above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could **reasonably** have been **expected** to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and **that** notice was given by the **OCHAMPUS**, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for **determining** tat provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable.

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff

of an institutional provider will be found to have also received written materials provided to the institutional provider.

e. The services that are at issue are the subject of what are generally considered acceptable standards of **practice** by the local medical community.

f. Preadmission authorization was available but not requested, or concurrent review requirements were not followed.

CHAPTER 6

AUTHORIZED PROVIDERS

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6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and **preauthorization** requirements of Chapter 4, providers may not hold patients **liable** for payment for certain services for which CHAMPUS payment is disallowed. With respect to such services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers **other** than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating providers but which are subject to the CHAMPUS **DRG-based** payment system in subsection A1, of Chapter 14 or **the CHAMPUS** mental health per diem payment system in subsection A".2. of Chapter 14 must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable CHAMPUS claim form and submitting it to the appropriate CHAMPUS fiscal intermediary on behalf of the beneficiary. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This certifies that the provider has agreed to accept the CHAMPUS-determined allowable charge or cost as payment in **full** for the medical services and supplies listed on the specific claim form; and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services and supplies.

1 9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant. I

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically **authorized** in this chapter to provide benefits under CHAMPUS. In addition, **to** be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an **active** duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c) . As a participating provider for active duty members, the **CHAMPUS** authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational "entity (such as hospital and skilled

nursing facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), **nor does it include other corporations that Provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.**

a. Preauthorization. The Director, **OCHAMPUS**, reserves the right to require **preauthorization** for admission to inpatient facilities. Refer to Chapter 4, subsection All., for information on preauthorization.

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a **CHAMPUS-determined** all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

2. Nondiscrimination policy. Except as provided below, payment may not be made for inpatient or outpatient care provided and billed by an institutional provider found by the Federal Government to practice discrimination in the admission of patients to its services on the basis of race, color, **or** national origin. Reimbursement may not be made to a beneficiary who pays for care provided by such a facility and submits a **claim** for reimbursement. In the following circumstances, the Secretary of Defense, or a designee, may authorize payment for care obtained in an ineligible facility:

a. Emergency care. Emergency inpatient or outpatient care.

b. Care rendered before finding of a violation. Care initiated before a finding of a violation and **which continues** after such violation when it is determined that a **change** in the treatment facility would be detrimental to the health of the patient, and the attending physician so certifies.

c. Other facility not available. Care provided in an ineligible facility because an eligible facility is not available within a reasonable distance.

3. Procedures for qualifying as a CHAMPUS-approved institutional provider. General and special hospitals otherwise meeting the qualifications outlined in paragraphs B.4.a., b., and c., of this chapter are not required to request CHAMPUS approval formally.

6 Declare an STF not eligible for CHAMPUS payment if that facility has been found to have engaged in fraudulent or deceptive practices.

(c) In general, the following disclaimers apply to treatment by **STFs**:

1 Just because one period or episode of treatment by a facility has been covered by CHAMPUS may not be construed to mean that later episodes of care by the same or similar facility will be covered automatically.

2 The fact that one case has been authorized for treatment by a specific facility or similar type of facility may not be construed to mean that similar cases or later periods of treatment will be extended CHAMPUS benefits automatically.

(2) Types of providers. The following is a list of facilities that have been designated specifically as STFS. I

(a) Free-standing ambulatory surgical centers. Care provided by freestanding ambulatory surgical centers may be cost-shared by CHAMPUS under the following circumstances:

1 The treatment is prescribed and supervised by a physician.

2 The type and level of care and services rendered by the center are otherwise authorized by this Regulation.

3 The center meets **all** licensing or other certification requirements of the jurisdiction in which the facility is located.

4 The center is accredited by the JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other standards as authorized by the Director, **OCHAMPUS**.

5 A childbirth procedure provided by a CHAMPUS-approved free-standing ambulatory surgical center shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement **of** this Regulation.

(b) PFTH facilities. STFS also include facilities that seek approval to provide care authorized under the PFTH. (Refer to Chapter 5 of this Regulation.)

(c) Substance use disorder rehabilitation facilities. In order to be authorized under CHAMPUS as a provider of substance use detoxification, rehabilitative services, outpatient treatment, and family therapy, substance use rehabilitation facilities, both freestanding facilities and hospital-based facilities, shall operate primarily for the purpose of providing treatment of substance use disorders (on either an inpatient (including partial care) or an outpatient basis) and shall meet the following criteria:

1 The course of treatment shall be prescribed by and supervised by a **qualified** mental health provider (refer to Chapter 4, paragraph **C.3.i.**) practicing within the scope of his or her license. When indicated by the patient's physical status, the patient shall be under the general supervision of a physician.

2 The type and-level of care provided by the facility are otherwise authorized by this Regulation.

3 The facility shall meet all licensing and other certification requirements of the jurisdiction in which the facility is located.

4 The facility shall be accredited by and shall remain in substantial compliance with standards issued by either the Joint Commission on Accreditation of **Healthcare** Organizations under the Consolidated Standards Manual, or the Commission Accreditation of Rehabilitation Facilities (**CARF**) or shall meet such other requirements as the Director, **OCHAMPUS**, finds necessary in the interest of the health and safety of the individuals who are furnished services in the facility.

5 The facility shall have entered into a participation agreement with OCHAMPUS within which the facility agrees, in part, to:

a Accept payment for its services based on an allowable-cost rate acceptable to the Director, **OCHAMPUS**, or such other method as determined by the Director, **OCHAMPUS**;

b Furnish OCHAMPUS with cost data certified to by an independent accounting firm or other agency as authorized by the Director, **OCHAMPUS** ;

c Accept the CHAMPUS-determined rate as payment in full and to collect from the **CHAMPUS** beneficiary those amounts that represent the beneficiary's liability, as defined in Chapter 4, and charges for services and supplies that are not a benefit of CHAMPUS;

d Make all reasonable efforts acceptable to the Director, OCHAMPUS, to collect those amounts which represent the beneficiary's liability, as defined in Chapter 4;

e Permit access by the Director, **OCHAMPUS**, to clinical records of CHAMPUS **beneficiaries** and to the financial and organizational records of the facility;

f Comply with the provisions of Chapter 8, and to submit claims first to all health insurance coverage to which the beneficiary is entitled that is primary to CHAMPUS.

6 The substance use rehabilitation facility shall not be considered to be a CHAMPUS-authorized provider and CHAMPUS benefits shall not be paid for services provided by the substance use rehabilitation facility until the date the participation agreement is signed by the Director, **OCHAMPUS**, or a designee.

7 The substance use" rehabilitation facility is not designated by the Health Care Financing Administration as an alcohol and drug abuse hospital for purposes of applicability of the Medicare prospective payment system.

k. Birthing centers. **A birthing** center is a freestanding or institution-affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

(1) Certification requirements. A birthing center which meets the following criteria may be designated as an authorized CHAMPUS institutional provider:

(a) The predominant type of service and level of care rendered by the center is otherwise authorized by this Regulation.

(b) The center is licensed to operate as a birthing center where such license is available, or is specifically licensed as a type of ambulatory health care facility where birthing center specific license is not available, and meets **all** applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the center is located.

(c) The center is accredited by a nationally recognized accreditation organization whose standards and procedures have been determined to be acceptable by the Director, **OCHAMPUS**, or a designee.

(d) The center complies with the CHAMPUS birthing center standards set forth in this Chapter.

(e) The center has entered into a participation agreement with **OCHAMPUS** in which the center agrees, in part, to:

1 Participate in CHAMPUS and accept payment for maternity services based upon the reimbursement methodology for birthing centers;

2 Collect from the CHAMPUS beneficiary **only** those amounts that represent the beneficiary's liability under the participation agreement and the reimbursement methodology for birthing centers, and the amounts for services and supplies that are not a benefit of the CHAMPUS;

3 Permit access by **the** Director, **OCHAMPUS**, or a designee, to the clinical record of any CHAMPUS beneficiary, to the

financial and organizational records of the center, and to reports of evaluations and inspections conducted **by** state or private agencies or organizations;

4 Submit claims first to all health benefit and insurance plans primary the CHAMPUS to which the beneficiary is entitled and to comply with the double coverage provisions of this Regulation.

5 Notify **OCHAMPUS** in writing within 7 days of the emergency transport of any CHAMPUS beneficiary from the center to an acute care hospital or of the death of any CHAMPUS beneficiary in the center.

(f) A birthing center shall not be a **CHAMPUS-authorized** institutional provider and CHAMPUS benefits shall not be paid for any service provided by a birthing center before the date the participation agreement is signed by the Director, OCHAMPUS, or a designee.

(2) CHAMPUS birthing center standards.

(a) Environment. The center has a safe and sanitary environment, properly constructed, equipped, and maintained to protect health and safety and meets the applicable provisions of the "Life Safety Code" of the National Fire Protection Association.

(b) Policies and procedures. The center has written administrative, fiscal, personnel and **clinical policies** and procedures which collectively promote the provision of high-quality maternity care and childbirth services in an orderly, effective, and safe physical and organizational environment.

(c) Informed consent. Each **CHAMPUS** beneficiary admitted to the center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

(d) Beneficiary care. Each woman admitted will be cared for by or under the direct supervision of a specific physician or a specific certified nurse-midwife who is otherwise eligible as a CHAMPUS individual professional provider.

(e) Medical direction. The center has written memoranda of understanding (MOU) for routine consultation and emergency care with an obstetrician-gynecologist who is certified or is eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology and with a pediatrician who is certified or eligible for certification by the American Board of Pediatrics or by the American Osteopathic Board of Pediatrics, each of whom have admitting privileges to at least one back-up hospital. In lieu of a required MOU, the center may employ a physician with the required qualifications. Each MOU must be renewed annually.

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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b From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital paid under this system;

c From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of another hospital that is excluded from the CHAMPUS DRG-based payment system because of participation in a statewide cost control program which is exempt from the CHAMPUS DRG-based payment system under subparagraph A.1.b.(1) of this chapter; or

d From the care of a hospital included under the CHAMPUS DRG-based payment system to the care of a uniformed services treatment facility.

3 **Payment in full to the discharging hospital.** The hospital discharging an inpatient shall be paid in full under the CHAMPUS DRG-based payment system.

4 **Payment to a hospital transferring an inpatient to another hospital.** If a hospital subject to the CHAMPUS DRG-based payment system transfers an inpatient to another such hospital, the transferring hospital shall be paid a per diem rate (except that in neonatal cases, other than normal newborns, the hospital will be paid at 125 percent of that per diem rate), as determined under instructions issued by OCHAMPUS, for each day of the patient's stay in that hospital, not to exceed the DRG-based payment that would have been paid if the patient had been discharged to another setting. However, if a discharge is classified into DRG No. 456 (Burns, transferred to another acute care facility) or DRG 601 (neonate, transferred less than or equal to 4 days old), the transferring hospital shall be paid in full .

5 **Additional payments to transferring hospitals.** A transferring hospital may qualify for an additional payment for extraordinary cases that meet the criteria for long-stay or cost outliers.

(4) **DRG system updates.** The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and uses annually updated items and numbers from the Medicare PPS as provided for in this Part and in instructions issued by the Director, OCHAMPUS. The effective date of these items and numbers shall correspond to that under the Medicare PPS except where distinctions are made in this chapter.

b. Applicability of the DRG system.

(1) **Areas affected.** The CHAMPUS DRG-based payment system shall apply to hospitals' services in the fifty states, the District of Columbia, and Puerto Rico, except" that any state which has implemented a separate DRG-based payment system or similar payment system in order to control costs and is exempt from the Medicare Prospective Payment System may be exempt from the CHAMPUS DRG-based payment system if it requests exemption in writing, and provided payment under such system does not exceed payment which would otherwise be made under the CHAMPUS DRG-based payment system.

(2) Services subject to the DRG-based payment system. All normally covered inpatient hospital services furnished to CHAMPUS beneficiaries by hospitals are subject to the CHAMPUS **DRG-based** payment system.

(3) Exempt from the DRG-based payment system. The following hospital services, even when provided in a hospital subject to the **CHAMPUS DRG-based** payment system, are exempt from the CHAMPUS **DRG-based** payment system. The services in subparagraphs **A.1.b. (3)(a) through (d) and (9) through (i)** shall be reimbursed under the procedures in subsection A.3. of this chapter, and the services in subparagraphs **A.1.b. (3)(e) and (f)** shall be reimbursed under the procedures in section G. of this chapter.

(a) **Services provided by hospitals exempt from the DRG-based payment system.**

(b) **All services related to kidney acquisition by Renal Transplantation Centers.**

(c) All services related to a heart transplantation which would otherwise be paid under DRG 103.

(d) **All services related to liver transplantation when the transplant is performed in a CHAMPUS-authorized liver transplantation center.**

(e) **All professional services provided by hospital-based physicians.**

(f) **All services provided by nurse anesthetists.**

(g) **All services related to discharges involving pediatric bone marrow transplants (patient under 18 at admission).**

(h) **All services related to discharges involving children who have been determined to be HIV seropositive (patient under 18 at admission).**

(i) **All services related to discharges involving pediatric cystic fibrosis (patient under 18 at admission).**

(j) **For admissions occurring on or after October 1, 1990, the costs of blood clotting factor for hemophilia inpatients. An additional payment shall be made to a hospital for each unit of blood clotting factor furnished to a CHAMPUS inpatient who is hemophiliac in accordance with the amounts established under the Medicare Prospective Payment System (42 CFR 412.115).**

(4) Hospitals subject to the CHAMPUS DRG-based payment system. All hospitals within the fifty states, the District of Columbia, and Puerto Rico which are certified to provide services to CHAMPUS beneficiaries are subject to the DRG-based payment system except for the following hospitals or hospital units which are exempt.

(a) Psychiatric hospitals. A psychiatric hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a psychiatric hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(b) Rehabilitation hospitals. A rehabilitation hospital which is exempt from the Medicare Prospective Payment System is also exempt from the CHAMPUS DRG-based payment system. In order for a rehabilitation hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(c) Psychiatric and rehabilitation units (distinct parts). A psychiatric or rehabilitation unit which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a distinct unit which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in Section 412.23 of Title 42 CFR.

(d) Long-term hospitals. A long-term hospital which is exempt from the Medicare prospective payment system is also exempt from the CHAMPUS DRG-based payment system. In order for a long-term hospital which does not participate in Medicare to be exempt from the CHAMPUS DRG-based payment system, it must have an average length of inpatient stay greater than 25 days:

1 As computed by dividing the number of total inpatient days (less leave or pass days) by the total number of discharges for the hospital's most recent fiscal year; or

2 As computed by the same method for the immediately preceding six-month period, if a change in the hospital's average length of stay is indicated.

(e) Sole community hospitals. Any hospital which has qualified for special treatment under the Medicare prospective payment system as a sole community hospital and has not given up that classification is exempt from the CHAMPUS DRG-based payment system. (See Subpart G of 42 CFR Part 412.)

(f) Christian Science sanatoriums. All Christian Science sanatoriums (as defined in paragraph B.4.h. of Chapter 6) are exempt from the CHAMPUS DRG-based payment system.

(9) Cancer hospitals. Any hospital which qualifies as a cancer hospital under the Medicare standards and has elected to be exempt from the Medicare prospective payment system is exempt from the CHAMPUS DRG-based payment system. (See 42 CFR Section 412.94.)

(h) Hospitals outside the 50 states, the District of Columbia and Puerto Rico. A hospital is excluded from the CHAMPUS DRG-based payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(5) Hospitals which do not participate in Medicare. It is not required that a hospital be a Medicare-participating provider in order to be an authorized CHAMPUS provider. However, any hospital which is subject to the CHAMPUS DRG-based payment system and which otherwise meets CHAMPUS requirements but which is not a Medicare-participating provider (having completed a form HCFA-1514, Hospital 'Request for Certification in the Medicare/Medicaid Program and a form HCFA-1561, Health Insurance Benefit Agreement) must complete a participation agreement with OCHAMPUS. By completing the participation agreement, the hospital agrees to participate on all CHAMPUS inpatient claims and to accept the CHAMPUS-determined allowable amount as payment in full for these claims. Any hospital which does not participate in Medicare and does not complete a participation agreement with OCHAMPUS will not be authorized to provide services to CHAMPUS beneficiaries.

c. Determination of payment amounts. The actual payment for an individual claim under the CHAMPUS DRG-based payment system is calculated by multiplying the appropriate adjusted standardized amount (adjusted to account for area wage differences using the wage indexes used in the Medicare program) by a weighting factor specific to each DRG.

(1) Calculation of DRG Weights.

(a) Grouping of charges. All discharge records in the database shall be grouped by DRG.

(b) Remove DRGs 469 and 470. Records from DRGs 469 and 470 shall be removed from the database.

(c) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right]^{5795} - 1.0$$

(d) Waae level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(e) Elimination of statistical outliers. All unusually high or low charges **shall** be removed from the database.

(f) Calculation of DRG average charge. After the standardization for indirect medical education, and area wage differences, an average charge for each DRG shall be computed by summing charges in a DRG and dividing that sum by the number of records in the DRG.

(9) Calculation of national average charge per discharge. A national average charge per discharge shall be calculated by summing all charges and dividing that sum by the total number of records from all DRG categories.

(h) DRG relative weights. DRG relative weights shall be calculated for each DRG category by dividing each DRG average charge by the national average charge.

(2) Empty and low-volume DRGs. The Medicare weight shall be used for any DRG with less than ten (10) occurrences in the CHAMPUS database. The short-stay thresholds shall be set at one day for these DRGs and the long-stay thresholds shall be set at the FY 87 Medicare thresholds.

(3) Updating DRG weights. The CHAMPUS DRG weights shall be updated or adjusted as follows:

(a) DRG weights shall be recalculated annually using CHAMPUS charge data and the methodology described in subparagraph A.1.c. (1) of this chapter.

(b) When a new DRG is created, CHAMPUS will, if practical, calculate a weight for it using an appropriate charge sample (if available) and the methodology described in subparagraph A.1.c.(1) of this chapter.

(c) In the case of any other change under Medicare to an existing DRG weight (such as in connection with technology changes), CHAMPUS shall adjust its weight for that DRG in a manner comparable to the change made by Medicare.

(4) Calculation of the adjusted standardized amounts. The following procedures shall be followed in calculating the CHAMPUS adjusted standardized amounts.

(a) Differentiate large urban, other urban, and rural charaes. All charges in the database shall be sorted into large urban, other urban, and rural groups (using the same definitions for these categories used in the Medicare program). The following procedures will be applied to each group.

(b) Indirect medical education standardization. To standardize the charges for the cost effects of indirect medical education factors, each teaching hospital's charges will be divided by 1.0 plus the following ratio on a hospital-specific basis:

$$1.43 \times \left[\left\{ 1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right\}^{.5795} - 1.0 \right]$$

(c) Wage level standardization. To standardize the charge records for area wage differences, each charge record will be divided into labor-related and nonlabor-related portions, and the labor-related portion shall be divided by the most recently available Medicare wage index for the area. The labor-related and nonlabor-related portions will then be added together.

(d) Apply the cost to charae ratio. Each charge is to be reduced to a representative cost by using the Medicare cost to charge ratio. This amount shall be increased by 1 percentage point in order to reimburse hospitals for bad debt expenses attributable to CHAMPUS beneficiaries.

(e) Preliminary base year standardized amount. A preliminary base year standardized amount shall be calculated by summing all costs in the database applicable to the large urban, other urban, or rural group and dividing by the total number of discharges in the respective group.

(f) Update for inflation. The preliminary base year standardized amounts shall be updated using an annual update factor equal to 1.07 to produce fiscal year 1988 preliminary standardized amounts. Thereafter, any development of a new standardized amount will use an inflation factor equal to the hospital market basket index used by the Health Care Financing Administration in their Prospective Payment System.

(9) The preliminary standardized amounts, updated for inflation, shall be divided by a system standardization factor so that total DRG outlays, given the database distribution across hospitals and diagnoses, are equal to the total charges reduced to costs.

(h) Labor and nonlabor portions of the adjusted standardized amounts. The adjusted standardized amounts shall be divided into labor and nonlabor portions in accordance with the Medicare division of labor and nonlabor portions.

(5) Adjustments to the DRG-based payment amounts. The following adjustments to the DRG-based amounts (the weight multiplied by the adjusted standardized amount) will be made.

(a) Outliers. The DRG-based payment to a hospital shall be adjusted for atypical cases. These outliers are those cases that have either an unusually short length-of-stay or extremely long length-of-stay or that involve extraordinarily high costs when compared to most discharges classified in the same DRG. Cases which qualify as both a length-of-stay outlier and a cost outlier shall be paid at the rate which results in the greater payment.

1 Length-of-stay outliers. Length-of-stay outliers shall be identified and paid by the fiscal intermediary when the claims are processed.

a Short-stay outliers. Any discharge with a length-of-stay (LOS) less than 1.94 standard deviations from the DRG's geometric LOS shall be classified as a short-stay outlier. Short-stay outliers shall be reimbursed at 200 percent of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the DRG amount divided by the geometric mean length-of-stay for the DRG.

b Long-stay outliers. Any discharge (except for neonatal services and services in children's hospitals) which has a length-of-stay (LOS) exceeding a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.82 shall be classified as a long-stay outlier. Any discharge for neonatal services or for services in a children's hospital which has a LOS exceeding the lesser of 1.94 standard deviations or 17 days from the DRG's geometric mean LOS also shall be classified as a long-stay outlier. Long-stay outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of the per diem rate for the DRG for each covered day of care beyond the long-stay outlier threshold. The per diem rate shall equal the DRG amount divided by the geometric mean LOS for the DRG.

2 Cost outliers. Additional payment for cost outliers shall be made only upon request by the hospital.

a Cost outliers except those in children's hospitals or for neonatal services. Any discharge which has standardized costs that exceed a threshold established in accordance with the criteria used for the Medicare Prospective Payment System as contained in 42 CFR 412.84 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c. (4) (d) and adjusting this amount for indirect medical education costs. Cost outliers shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

b Cost outliers in children's hospitals and for neonatal services. Any discharge for services in a children's hospital or for neonatal services which has standardized costs that exceed a threshold of the greater of two times the DRG-based amount or \$13,500 shall qualify as a cost outlier. The standardized costs shall be calculated by multiplying the total charges by the factor described in subparagraph A.1.c.(4)(d) (adjusted to include average capital and direct medical education costs) and adjusting this amount for indirect medical education costs. Cost outliers for services in children's hospitals and for neonatal services shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold.

c Cost outliers for burn cases. All cost outliers for DRGs related to burn cases shall be reimbursed the DRG-based amount plus a percentage (as established for the Medicare Prospective Payment System) of all costs exceeding the threshold. The standardized costs and thresholds for these cases shall be calculated in accordance with subparagraph A.1.c.(5)(a) 2 a and subparagraph A.1.c.(5)(a) 2 b.

(b) Wage Adjustment. CHAMPUS will adjust the labor portion of the standardized amounts according to the hospital's area wage index.

(c) Indirect Medical Education Adjustment. The wage adjusted DRG payment will also be multiplied by 1.0 plus the hospital's indirect medical education ratio.

(d) Children's Hospital Differential. With respect to claims from children's hospitals, the appropriate adjusted Standardized amount shall also be adjusted by a children's hospital differential.

1 Qualifying children's hospitals. Hospitals qualifying for the children's hospital differential are hospitals that are exempt from the Medicare Prospective Payment System, or, in the case of hospitals that do not participate in Medicare, that meet the same criteria (as determined by the Director, OCHAMPUS, or a designee) as required for exemption from the Medicare Prospective Payment System as contained in 42 CFR 412.23.

2 Calculation of differential. The differential shall be equal to the difference between a specially calculated children's hospital adjusted standardized amount and the adjusted standardized amount for fiscal year 1988. The specially calculated children's hospital adjusted standardized amount shall be calculated in the same manner as set forth in subparagraph A.1.c.(4), except that:

a The base period shall be fiscal year 1988 and shall represent total estimated charges for discharges that occurred during fiscal year 1988.

b No cost to charge ratio shall be applied.

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c Capital costs and direct medical education costs will be included in the calculation.

d The factor used to update the database for inflation to produce the fiscal year 1988 base period amount shall be the applicable Medicare inpatient hospital market basket rate.

3 Transition rule. Until March 1, 1992, separate differentials shall be used for each higher volume children's hospital (individually) and for all other children's hospitals (in the aggregate). For this purpose, a higher volume hospital is a hospital that had 50 or more CHAMPUS discharges in fiscal year 1988.

4 Hold harmless provision. At such time as the weights initially assigned to neonatal DRGs are recalibrated based on sufficient volume of CHAMPUS claims records, children's hospital differentials shall be recalculated and appropriate retrospective and prospective adjustments shall be made. To the extent practicable, the recalculation shall also include reestimated values of other factors (including but not limited to direct education and capital costs and indirect education factors) for which more accurate data became available.

5 No update for inflation. The children's hospital differential, calculated (and later recalculated under the hold harmless provision) for the base period of fiscal year 1988, shall not be updated for subsequent fiscal years.

**G. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER
NON-INSTITUTIONAL HEALTH-CARE PROVIDERS**

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. **In general.** The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lowest of the billed charge, the prevailing charge level or the appropriate charge level.

b. **Prevailing charge level.**

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis, then adjusted for localities in accordance with paragraph G.1.d. of this section.

(2) The national prevailing charge level referred to in paragraph G.1.b. (1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b. (2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS, determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Resister.

c. **Appropriate charge level.** Beginning in calendar year 1992, the appropriate charge level shall be calculated on a national basis, then adjusted for localities in accordance with paragraph G.1.d. of this section. The appropriate charge level for each procedure is the product of the following two-step process:

(1) **Step 1: Procedures classified.** All procedures are classified into one of three categories, as follows:

(a) **Overpriced procedures.** These are the procedures for which the prior year's national appropriate charge level or national prevailing charge level, whichever is less, exceeds the Medicare converted relative value unit (CRVU) by greater than 150 percent. For purposes of the

preceding sentence the **CRVU** is the Medicare Resource-Based Relative Value Scale relative value unit, converted to a dollar value by using the applicable Medicare conversion factor. For any particular procedure for which comparable **CRVU** and **CHAMPUS** data are unavailable, but alternative data are available that the Director, **OCHAMPUS** (or designee) determines provide a reasonable approximation of relative value or price for purposes of the comparison required by this paragraph, the comparison may be based on such alternative data.

(b) Other Procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the primary care procedures group.

(c) Primary care procedures. These are primary care procedures, excluding overpriced procedures. The **CHAMPUS** definition of primary care includes maternity care and delivery services and well baby care services.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's appropriate charge levels as follows:

(a) For overpriced procedures, the prior year's appropriate charge level for each procedure shall be reduced by the lesser of: the percentage by which it exceeds 150 percent of the Medicare converted relative value unit or fifteen percent.

(b) For other procedures, the prior year's appropriate charge level for each procedure shall be continued.

(c) For primary care procedures, the prior year's appropriate charge level shall be adjusted by the Medicare Economic Index (MEI), as the MEI is applied to Medicare prevailing charge levels.

d. Calculating prevailing charge levels and appropriate charge levels for localities. The national prevailing charge levels determined pursuant to paragraph G.1.b. of this section and the national appropriate charge levels calculated pursuant to paragraph G.1.c. of this section will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

e. Special rules for 1991.

(1) Appropriate charge levels for care provided on or after January 1, 1991, and before the 1992 appropriate charge levels take effect shall be the same as those in effect on December 31, 1990, except that appropriate charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which an appropriate charge level was in effect immediately prior to

October 7, 1991. For each procedure, the appropriate charge level shall be the appropriate charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent.. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

{3) For purposes of this paragraph G. 1. e. , "appropriate "charge levels in effect at any time prior to October 7, 1991 shall mean the lesser of:

(a) The prevailing charge levels then in effect, or

(b) The fiscal year 1988 prevailing charge levels adjusted by the Medicare Economic Index (MEI) was applied beginning in fiscal year 1989.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS allowable charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f. (1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the

adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2) (b) of this section for purposes of the 1991 prevailing charge level.

9* Adjustments and Procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. A charge that exceeds the prevailing charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform *component services of a procedure other than assistant-at-surgery* (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an **assistant-at-** surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 c.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive **per diem rate**, shall be denied; with the exception of independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries.

Alternative methods may not result in reimbursement greater than the **allowable charge method above.**

H. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care Professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

I. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special abdications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both. the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of **OCHAMPUS** may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

J. OUTSIDE **THE** UNITED STATES

The Director, **OCHAMPUS**, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

K. IMPLEMENTING INSTRUCTIONS

The Director, **OCHAMPUS**, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.